
The task of nursing ethics

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Author's abstract

This paper raises the questions: 'What do we expect from nursing ethics?' and 'Is the literature of nursing ethics any different from that of medical ethics?' It is suggested that rather than develop nursing ethics as a separate field writers in nursing ethics should take a lead in making the patient the central focus of health care ethics. The case is made for empirical work in health care ethics and it is suggested that a good way of setting about this is to ask practising nurses about the real ethical problems they encounter.

There is a lack of empirical work in the literature concerned with nursing ethics. It is my contention that this gap has left the way open for the development of a particular kind of writing, a rather prescriptive Olympian style of handed down ethics. This trend has led to a focus on particular philosophers and this in turn has helped to shape the area of applied ethics that has come to be known as nursing ethics. These issues are at the heart of the question: 'What should nursing ethics look like?'

Nursing ethics is a difficult area of study to apprehend, especially if it is to be considered as an entity in its own right, that is, in some way separate from **medical** ethics or **bioethics**. Nursing has a particular relationship with medicine within the organisational structure of health care and, indeed, in the hierarchy of occupations. In so far as any occupation can claim autonomous professional status and operate within a bureaucracy, medicine has managed to lay claim to and maintain professional status, in that it has control of its work and membership. Nursing work is dependent in part on medical practice and so the occupation can at best only lay claim to semi-professional status. This dependence on medicine means that nursing, when it wishes to develop itself, has a tendency to want to pull away and engage in uniquely **nursing** activities and debates.

I shall argue that nursing has a particular contribution to make to the ethics and health care debate, but that the contribution need not necessarily be the production of nursing ethics in contradistinction to medical ethics or bioethics. Rather, nursing could take advantage of the fact that its work requires a particularly close and continuing contact with patients and so contribute to the ethical debates a consideration of the patient's perspective. Instead of discussing autonomy, rights, beneficence etc nursing could start at the patient experience and ask what in the context of their condition, be it stroke, amputation, AIDS or whatever, does it mean to take care of a patient and give consideration to his or her autonomy, rights and freedom. Nursing's contribution, therefore, would not be to create nursing ethics but to inject health care ethics with a more patient/client-led perspective. In order to do this the field stands in need of empirical work and some consideration of two questions, first, what currently counts as nursing ethics and second, what it is that we expect of nursing ethics? What, in other words, is the task of nursing ethics?

Over the last decade a considerable body of literature has built up in the area of nursing ethics. Some of the first writings on nursing ethics appeared in the United States literature at the turn of the century, with a considerable amount being written in the first twenty years or so. There was not a lot written on the subject in the 1940s and 1950s, but there was a steady rise from the 1970s to the present day. Speculations on ethical questions are becoming increasingly popular, both in the general and the nursing press.

It might be argued that the efforts that nursing is making in an attempt to achieve professional status could have something to do with the increasing interest in ethics. The production of nursing ethics texts could be seen as no more than a consequence of a growing number of academic departments of nursing. Whatever the aetiology, it remains the case that nurses are now plainly interested in the ethical dimension of health care. Nursing ethics exists as a phenomenon with a life of its own and it is unlikely to go away.

Key words

Nursing ethics; care; health care ethics; research.

As a contributor (1) to the nursing ethics literature, for me to suggest that nursing ethics has no right to an independent existence or that the motivation for ethical debate within nursing is not all that it should be is perhaps disingenuous. However, the time has come when questions have to be asked about the nature and purpose of nursing ethics.

I have changed my perspective on nursing ethics over the last few years. After ten years of working in the field of bioethics, first on research projects involving a multidisciplinary research approach to bioethics and latterly writing about nursing ethics, I am still not altogether sure that we need a thing called '**nursing ethics**', as opposed to a more generalised '**health care ethics**' (2). Why should we consider nursing ethics as an area of concern which is independent of medicine? Would an adequate notion of nursing ethics not simply be a reflection of medical ethics? The general argument that is put forward for the existence of nursing ethics is that the occasions giving rise to ethical concern are often the same for nursing as for medicine – abortion, euthanasia, care of the mentally ill, reproductive technology, intensive care, prolongation of life – but the difference for ethical debate lies in the way the issues present and the nature of the practical problems they bring.

The medical profession is often deemed to have the last word in ethical decisions, albeit in the guise of clinical judgement, because it is ultimately legally responsible for the patient's welfare. This is a fact that nurses sometimes refuse to accept, or so it would seem in some of the debates about the independent practice of nursing. If, however, we concern ourselves with the situation that currently prevails we have to conclude that the patient has a contract, both legal and moral with the doctor, not with the nurse. Some of the most notable cases where nurses have challenged doctors on moral grounds have been fundamentally flawed because nurses were making challenges from a weak position. This is true in the cases where student nurses, often with the backing of qualified staff, have refused to take part in electro-convulsive therapy (ECT) sessions or refused to administer drugs because they believed it was not in the best interests of the patients. It would seem to me that unless a psychiatrist is prescribing and administering ECT in a way that is not compatible with the code of practice of the College of Psychiatry, then the nurse has no grounds for complaint and non co-operation. Doctors' decisions of that nature are made on clinical grounds; psychiatrists' training makes them licensed practitioners with a mandate to make clinical decisions; this mandate is recognised by society. The nurses' training has a different end-goal. One might want to argue with this state of affairs, but as things currently stand it is quite clear that certain powers lie with doctors and little can be gained for patient care, or, for that matter, nursing ethics by individual nurses taking side-swipes at individual

doctors exercising these powers. One only has to take a look at other areas of psychiatric care (3) to see that nurses have a lot to do to put their own house in order, before invading medical territory.

This rather military-style language draws attention to the fact that much of what we are dealing with in ethical debates in nursing and in health care generally is professional territoriality and power. Nursing's position in relation to medicine is, then, to a large extent determined by power. Issues of power and control essentially define the domain of the concerns of nurses and this includes ethical concerns. Doctors may take the decision to discontinue care – nurses have to put that decision into practice. Doctors, for instance, may admit a patient on a voluntary basis, it is the nurse that has to 'keep' the patient in the ward. Nursing ethics has, then, so the argument goes, a claim to an existence that is separate from and independent of, medical ethics. I know this argument well and have made it as a justification for writing about nursing ethics (4). However, before nursing ethics gets to be very much older, I think we should take a close look at this justification and the product that it allows, namely **nursing ethics**.

Lest this paper appears to be rather too damning, I should make it clear that I do think nurses must take ethics seriously and debate the issues – it is the nature of that enterprise and its rhetoric that I am questioning.

Who is responsible for what?

We must look behind the rhetoric if we are to determine just what it is that nursing ethics might be about – the task of nursing ethics. It seems to me that the nursing ethics literature is by and large no more than a mirror image of the medical or bioethics literature. It tends to discuss the same issues, dilemmas and philosophers. There may be a good reason for this. It could be that to sustain the notion of nursing ethics as a separate entity is easier said than done and so one would not expect to find much difference between the nursing and medical ethics texts. It is perhaps the interplay between the two perspectives on ethical issues – medicine's and nursing's – that has been neglected.

Much of the nursing contribution to ethical debates centres around the idea of doctors' values being hidden in clinical decisions and dressed up as 'professional judgement'. Because of the nature of the power distribution between medicine and nursing many ethical discussions come down to the nature of interdisciplinary work and to the question of who is responsible for what. We need to unpack and examine some of the value judgements and stands that are embedded in 'clinical judgements', which are largely the product of medicine. Nurses deal, for the most part, with the consequences of these decisions and judgements. It should not be forgotten, though, that nurses for their part have

value judgements embedded in their own clinical practice and decisions. These, too, require examination.

A review of the literature reveals any number of introductions to ethics for nurses so that we can all become adept at recognising a utilitarian argument or a deontological approach to a situation, but there exists very little about what nurses in practice make of it all. This is very possibly because philosophers, unlike sociologists, do not tend to go on data-gathering expeditions, instead they come by cases in a rather more particular way and reflect upon them. Jennings (5) has argued that it is too simplistic an explanation to say that social scientists study what is, and ethicists what ought to be. He argues that bioethicists do have empirical experience of the areas they study: perhaps it is not fieldwork as a social scientist might define it, nevertheless, bioethicists are not writing in a vacuum. However, there is a tendency for philosophers to concentrate on the spectacular rather than the everyday. Nurses in practice, then, tend to be presented with a literature of dilemmas and labels (Kantian, Utilitarianism, Rights, Justice, Beneficence etc). These ethics texts, with the possible exception of the case-based discussions, do not in any real sense add to the literature.

A fairly standard pattern

Ethical issues for nurses are invariably bound up with organisational, structural and inter-professional factors and, of course, with the question of power. The ways in which care is organised and the nature of the working relationships between the professionals involved both have a bearing on the ethical decisions that are made. I would argue that the nursing ethics literature as it currently stands has not made a convincing case for the existence of **nursing** ethics as distinct from **medical** ethics, or more widely, and perhaps desirably, health care ethics. A look through the nursing ethics literature reveals a fairly standard pattern and approach to the subject matter. The authors tend to be philosophers or philosophers and nurses, although this is not uniformly the case. A typical nursing ethics text will contain a few remarks about why it is a **nursing** ethics work – these generally range around the idea that moral issues tend to present themselves to nurses in ways that differ from the medical profession's experience of moral issues. These texts then proceed in greater and lesser detail and sophistication to mirror medical ethics books. There is a good deal of case discussion; some texts are more or less devoted to case-based discussion. They describe ethical principles and theories focusing, by and large, on respect for persons, autonomy, informed consent, justice and beneficence, drawing mostly upon Kant and Mill.

Jameton (6), in his work, *Nursing Practice – the Ethical Issues*, comes closest to making a case for

philosophers paying attention to **nursing** ethics when he describes his book as

‘a philosopher’s approach to bioethical issues as they arise in and are shaped by nursing practice’.

This promise stands largely unfulfilled.

The standard justification for nursing ethics, leaning heavily as it does on the fact that ethical issues present themselves to nursing in a different way from the medical profession's experience of ethical issues, is a good enough case to get nurses into ethics; whether they have to get into **nursing** ethics is perhaps another matter.

Let us take a closer look at the substantive issues covered in the nursing ethics literature. That nursing ethics texts, by and large, tend to mirror medical ethics or bioethics texts has the disadvantage of producing nothing new and possibly serves to marginalise nursing in the wider health care debates. Whilst it is the case that most nursing ethics texts are almost indistinguishable from medical ethics texts, there have been obvious efforts to carve out an area on which nursing ethics can focus. This has resulted in the emergence of two main trends. The first is a tendency to write about the nurse as the **patient's advocate** and the second is a concentration on the **ethics of caring** and to appropriate caring as nursing's business. These avenues are problematic both for nursing ethics and health care ethics in general. Advocacy and the ethics of caring, if they are to be linked firmly to nursing, could cause tensions with the profession of medicine by suggesting that doctors don't care and place patients in need of an advocate.

Advocacy has adversarial connotations

Let us first look at advocacy. The main difficulty with this position is that advocacy has adversarial connotations. The advocacy route, then, is not necessarily a useful way for nursing to go. First, because there is no reason to suppose that nurses can be sufficiently removed from the organisation and the ideologies of health care and from nursing's own ideologies, to make and plead a patient's case as an advocate would have to do. It might also bring a nurse into conflict with his or her duty to care. Is the nurse going to plead the case for a patient if it is not in his best clinical interests? How do we balance the nurse's duty to care and the patient's right to self-determination? Also, to set the nurse up as the patient's advocate suggests that the rest of the health care professionals and the system are working against the patient's best interests: this might well be true, but nurses cannot claim to be neutral players in the game. Nurses have power, by virtue of their knowledge and familiarity with the system, whereas patients are, in general, vulnerable. So at best the activity of the nurse-as-advocate is likely to resemble benevolent paternalism on the part of the nurse and

trusting acceptance on the part of the patient. Nurses may simply have to live with the moral uncertainty which accompanies their attempts to act in the best interests of the patient. It is precisely in these kinds of areas that we lack empirical work.

The ethics-of-caring literature is for the most part rather vague and possibly ill-founded. It deals in exhortations and rather idealistic notions of caring for individuals, leaving aside the institutional and organisational reality of most care. It also treats as unproblematic the fact that care is rather too general a notion for nursing to claim as its focus of professional activity. In other words caring can be widely defined and is something that lay people do frequently and well. It is therefore difficult to see how nursing could make a success out of constructing an ethics-of-caring literature that would further either nursing or caring.

So, if we are to cast doubt on advocacy and the ethics of caring, what direction should nursing ethics take? What might be the proper area of study for nursing ethics? The criticism that I have made of nursing ethics thus far has mainly to do with the fact that nursing appears to be more concerned with delineating what might be recognised as nursing ethics than with anything else. It then becomes all too easy to use nursing ethics as a cover for encroaching on doctors' territory and for criticising doctors (doctor-bashing). The patient tends to become part of the battleground, or at least an entity in the professional boundaries debates.

So what of the development of nursing ethics?

Professional aspirations can shape a discipline and its activities as much as anything else. We can, I think, include the philosophers in the professional territory arguments. It is perhaps not without significance that as the cuts in university finances hit the arts faculties, moral philosophers are looking for areas in which to apply their discipline. Teaching of medical ethics or health care ethics provides one outlet and the role of the hospital ethicist another. The idea of having an ethicist in the hospital is gaining acceptance in the US and is talked about in, but has not yet taken off in, the UK. It will be interesting to see how long the hospital ethicist can stay on the outside of the inter-professional wrangling that teamwork involves. There could come a day when the doctors are toppled from their position of dominance and replaced by the ethicist or philosopher. Whether ethicists should be drawn from the ranks of the health care professions or from departments of philosophy is a point for debate.

There is possibly a parallel between the partnership that Jennings (5) suggests would benefit both social science and bioethics, and a partnership which might benefit nursing ethics and nurse theorists working on the concept of nursing care.

If nursing ethics is to develop usefully, one route it might take would be to focus upon the patient rather than to concentrate on professional codes and aspirations. The ethics of caring in its present form does not have a lot to commend it but it does at least start to focus on practice and the patient. Nurses have the advantage of being rather more constantly with the patient than are other professionals and because they are able to co-ordinate the care that the patient receives from various quarters, they have some view of what life is like for the patient. This vantage point means that nurses are placed in a position where they at least have some idea of patients' experience of care. Nurses are then well placed to make the case for studying care from the patient's perspective. This vantage point should not be overstated: only the patient knows the patient's view.

William May (7), a theologian working in bioethics, makes the case for a study of the ethics of suffering. He argues that patients and families are left to cope when the professionals have had their ethical debate and made their decision. In other words, the professionals might have handled their ethical dilemma but the patient and family still have to come to terms with and somehow live with the outcome. His argument is of interest here because it suggests that the focus should be on the patient and practice rather than on the profession. Nursing has perhaps tended to focus on the professionals' role in ethical decisions (for very good reasons) but has, in so doing, lost sight of the patient.

Nurses might further health care ethical debate in general by making a case for placing more emphasis on the patient. Nursing could play an important part in health care ethics by introducing a larger element of the *is* of health care organisation and practice and placing less emphasis on the *ought*. This fits with Jennings's (5) suggestion that social science and bioethics have much to learn from each other.

Caring is clearly an all-important part of nursing and other health care professionals' work, yet if we focus solely on this there is a danger of leaving the patient's experience out of the equation. As the patient-experience and the practice of caring are closely bound together it would make good sense to give due emphasis to both.

An ethnographic approach to the study of patients' experiences of different diseases and traumas that give rise to ethical dilemmas would add to our knowledge. Sociologists have much to offer in this area. It would help also if we could obtain rather more of an idea of what nurses in practice regard as the morally problematic areas of their work. We should ask questions such as: 'Do moral philosophical debates have relevance for practice?' and 'What are the concerns of those working in the areas of patient care?' rather than simply taking the works of Kant, Mill and Rawls (these are typically the authors that the philosophers have seen fit to present bioethical discussions through) and then

trying to make judgements about nursing practice through the particular approaches of those philosophers. Starting with the practice rather than the philosophy might lead us to other texts.

I am currently working on a research project which has as its focus staff nurses' accounts of the moral aspects of their work. It involves an ethnographic approach with informal interviews, the aim being to discover what those who work in the patient-care areas think about the moral dimension of their practice and of the current ethical debates. In addition to the interview data there are field-notes from participant observation in intensive care units. This observation was included so that the study would include data from the areas which are so often discussed in abstract terms in ethics texts.

If nursing is to make a contribution to the health care-ethics debates, either as **nursing** ethics or as part of a wider enterprise, it seems to me that it should concentrate on the issues as they present in a very practical manner and examine the fine details of nursing care. Nurses face the big dilemmas that come with high-tech care and new reproductive possibilities etc but they are also involved in the more everyday moral choices that arise when the care of one human being is placed in the hands of another.

Nurses could make a significant contribution to the discussion of rights, freedom, autonomy and choice in health-care settings if they paid close attention to the 'data' of everyday nursing and perhaps became rather less concerned with the

activities of other health care professionals and with their own professional standing within the wider context of health care.

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References and notes

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- (4) See reference (1): Melia K M. *Everyday nursing ethics*.
- (5) Jennings B. Ethics and ethnography in neonatal intensive care. In: Weisz G. *Social science perspectives on medical ethics*. Dordrecht: Kluwer Academic Publishers, 1989.
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- (7) May W. Personal comment made at a meeting at the Hastings Center, New York, 1989.

News and notes

Confidentiality and People under 16

Guidance on *Confidentiality and People under 16* has been issued in the form of a leaflet by the British Medical Association, the General Medical Services Committee, the Health Education Authority, the Brook Advisory Centres, the Family Planning Association and the Royal College of General Practitioners.

It points out that: many teenagers risk pregnancy

rather than seek contraceptive advice; many teenagers mistakenly fear that their GP cannot respect their confidentiality; the duty of confidentiality owed to a person under 16 is as great as that owed to any other person, and any competent young person, regardless of age, can independently seek medical advice and give valid consent to medical treatment.

News and notes

New Medical Ethics Department

A new Medical Ethics Department has been established at the Marmara University, Medical School in Istanbul, Turkey.

Contributions to the new department's library and archives in terms of copies of articles and books will be very welcome, and would be deeply appreciated.

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